

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

946

CERTIFICATE OF DEATH

08255

Reg. Dist. No.

254

1. PLACE OF DEATH:

County

Green Anne

City or town

Rural, Edge Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

all his life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Bennett Cleveland Allen

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Eliza Harrington Allen

7. Birth date of deceased (mo., day, yr.)

May 13 - 1884

6. (c) If alive, give age years

58

8. AGE:

Years
61Months
3Days
2

If less than one day

hrs. min.

9. Birthplace

near Edge Mills 2nd Rd Del

(Town, county, and state)

10. Usual occupation

Contractor & Builder

11. Industry or business

Farmer & Merchant

FATHER

12. Name

John Wesley Allen

13. Birthplace

Tolbot Co. Md.

MOTHER

14. Maiden name

Catherine Griffith

15. Birthplace

Delaware

16. Informant

Bennett C Allen Jr

Address

Edge Mills, Maryland

17. Burial

Burial

Date thereof

Aug 18 - 45
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Old Edge

Location

Edge Mills, Maryland

18. Funeral director

Barton Bros

Address

Centerville, Maryland

19. Aug. 18 1945

H M Aldridge

(Date read by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Maryland

Green Anne

City or town

Edge Mills

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

no

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15-

1945 at 11²⁰ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 -

1944, to Aug 15 - 1945

and that I last saw him alive on Aug 15 - 1945

1945

Immediate cause of death

Angina Pectoris

1/2 hour

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

W. Henry Fisher

M. D. or other

8/16-45

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 118

CERTIFICATE OF DEATH

Reg. Dist. No. 251

08255

1. PLACE OF DEATH:

County

Queen Anne's
Rural Millington Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Wilbert L. Duckery

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Child

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 27 1944

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day

—

60

20

—

hrs.

—

min.

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RECEIVED

SEP 1 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1275

CERTIFICATE OF DEATH

08257

253

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Aug 1 1893

8. AGE:

Years	Months	Days	If less than one day
52	5	11	hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address

1228 Jones Road 1300

Buried

(Burial, cremation, or removal. Which?)

Date thereof. 8/15/45

(month) (day) (year)

Cemetery or crematory.....

Stevensville Md

Location.....

Stevensville

18. Funeral director.....

Address

Stevensville Md

19. Date rec'd by registrar

8/15 1945

F.C. Thomas

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Aug 15 1945

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Aug 14 1945 to Aug 15 1945

and that I last saw her alive on Aug 15 1945

Immediate cause of death.....

Pneumonia

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

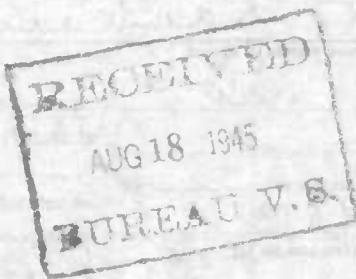
M. D. or other

Address.....

Stevensville Md Date signed 8/15/45

RECEIVED BY TELETYPE STATE OF CALIFORNIA

TELETYPE MESSAGE CENTER





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

18258

CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH:

County..... Queen Anne
City or town..... Kingston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 7 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Charles D. Quigley

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1878

6. (c) If alive, give age..... years

8. AGE: Years	Mooths	Days	If less than one day
66	10	4	hrs. min.

9. Birthplace..... Kent Co. Maryland

(Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business

12. Name..... Thomas Quigley

13. Birthplace..... Ireland

14. Maiden name..... Susanna McKee

15. Birthplace..... Ireland

16. Informant..... Mrs. Mary Agnes Drew

Address..... Chestertown, Md. R.F.D.

17. Burial..... Date thereof Aug. 11, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Saint Dennis Cem.

Location..... Kent Co. Maryland

18. Funeral director..... J. Willis Wells

Address..... Chestertown, Md.

19. Aug. 11, 1945. Edgerton Lane

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

County..... Kent

State..... Md.

City or town..... Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No..... R.F.D.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 11, 1945 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1935 to Aug. 8, 1945

and that I last saw h. in alive on 8-8 1945

Immediate cause of death

Cerebral hemorrhage
Paralysis of left side

Due to

Hypertension

Due to...from endo.-myocarditis

Other conditions

Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

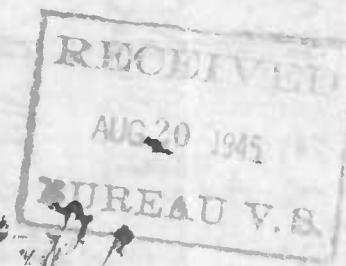
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... Edward A. Burgess, M.D. or other

Address..... Rock Hall, Md. Date signed 8/10/45



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

08259

253

Reg. Dist. No.

1. PLACE OF DEATH: Tuey's Acre
 County Chester
 City or town Chester
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 57 yrs
 Hospital, Institution, or street address where death occurred:
8 Mex.
 How long in hospital or institution?

3. (a) FULL NAME Oscar Alwood Schely

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
6. (b) Name of husband or wife <u>Maude N. Schely</u>		
6. (c) If alive, give age <u>47</u> years		
7. Birth date of deceased (mo., day, yr.) <u>Aug 26 - 1893</u>		

8. AGE:	Years <u>51</u>	Months <u>11</u>	Days <u>28</u>	If less than one day hrs. _____ min. _____
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9. Birthplace Chester - Md
(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business Oyster & Fishing
 Father Gustave Schely

Mother Bertha
 12. Name Alvina
 13. Birthplace Berkeley

14. Maiden name Alvina
 15. Birthplace Berkeley

16. Informant Mrs. Maude N. Schely
 Address Chester, Md

17. Burial Date thereof Aug 19-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Steveeville

Location Steveeville - Md

18. Funeral director Garton Bros
 Address Steveeville, Md

19. 8/18 Date rec'd by registrar 1945
 Address H.C. Thomas
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 State Maryland County Tuey's Acre
 City or town Chester
(If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
(If rural, give LOCATION)
 2.(a) If veteran, name war World War #1

3. (b) Social Security Number 218-07-7015

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1945 al 5 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Aug 16 1945 and that I last saw alive on Aug 16 1945.
 Immediate cause of death Tuberculosis of lungs

DURATION 1 yr.
 Due to _____
 Due to _____
 Other conditions Diabetes DURATION 3 mos.
(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

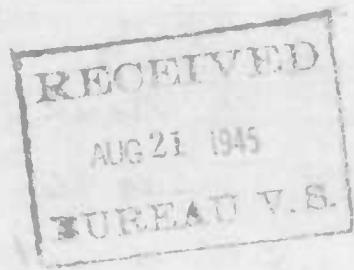
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE WChas. E. Snyder M. D. or other _____ Date signed 8/17/45

Address Steveeville



1
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of MARYLAND STATE DEPARTMENT OF HEALTH
name of town of death is shown on 2411 N. Charles St., Baltimore 460

FILE NO. G 97 AUG 31 1945

08260

CERTIFICATE OF DEATH

Reg. Dist. No. 21-3

1. PLACE OF DEATH:

County

Greenbush

City or town

Chester

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Nita Marilee Seward

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Married Westfield Seward

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

58

4

30

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

MOTHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Whichever)

Date thereof

(month) (day) (year)

Cemetery or crematory

Stevensville

Location

Stevensville and

18. Funeral director

Oppy & Lane

Address

Church Hill Md

19. (Date rec'd by registrar)

19. 8/14

19. 45

J.C. Thomas

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

maryland County Queen Anne's

City or town

Chester (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 17 1945 9 P.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from

Aug 17 1945 to Aug 17 1945

and that I last saw her alive on Aug 17 1945

Immediate cause of death

Pneumonia, liver

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Beth S. Seward

M. D. or other

Address

Stevensville Md Date signed 8/14/45



PLEASE WRITE PLAINLY WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 232

CERTIFICATE OF DEATH

18261

Reg. Dist. No. 251

1. PLACE OF DEATH:

County

Queen Anne's
Rural Mc. Ginnis Cr.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

John A. Lewis

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

April 23 1865

6. (c) If alive, give age years

8. AGE:

Years
80Months
4Days
2

If less than one day

hrs.
min.

8. Birthplace

Delaware

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

John Lewis

13. Birthplace

Delaware

MOTHER

Mary unknown

15. Birthplace

Delaware

18. Informant

Edward Lewis

Address

Millington Md

17. Burial

Burial Date thereof Aug 29 1940

(Burial, cremation, or removal. Which)

(Month) (day) (year)

Cemetery or crematory

Protestant Cemetery

Location

Mc. Ginnis Corner Md.

18. Funeral director

Edward O'Leary

Address

Millington Md

19. Aug 28 1940

Edgar S. Lane

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Md. Queen Anne's
Rural Mc. Ginnis Corner Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 25

1940 at 11 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 10 1940 to Aug 25 1940

and that I last saw him alive on Aug 25 1940

Immediate cause of death

Hepatitis

Due to

Hepatitis

DURATION

2 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

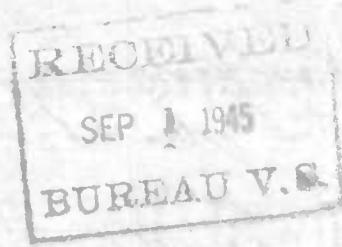
23. SIGNATURE

G. L. Cofland M.D.

M. D. or other

Address

Millington Md Date signed Aug 27 1940



M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-2

08262

CERTIFICATE OF DEATH

Reg. Distr. No. 251

1. PLACE OF DEATH:

County..... Queen Anne's
 City or town..... Near Millington (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Palmerton Nursing Home

How long in hospital or institution?

3. (a) FULL NAME

William T. Farr

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male 20

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

May unknown 1857

8. AGE:

Years

Months

Days

11 less than one day

hrs. min.

9. Birthplace.....

(Town, county and state)

Queen Anne Maryland

10. Usual occupation.....

Retired Oysterman

11. Industry or business

MOTHER FATHER

12. Name..... William T. Farr

13. Birthplace..... Maryland

14. Maiden name..... Margaret Yorktown

15. Birthplace..... Maryland

16. Informant..... Mrs. C. M. Thompson

Address..... 726 N. Broadway Baltimore

Burial Date thereof..... Aug 11 1864
(Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory..... Cemetery

Location..... Cambridge Md.

18. Funeral director..... Edward Eller

Address..... Millington

19. (Date rec'd by registrar) Edgar L. Lake

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County..... Queen Anne's

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug. 10 1945 at S.P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1945, to Aug. 10, 1945, and that I last saw him alive on Aug 8 - 1945.

Immediate cause of death..... Natural Death

Natural Death

DURATION

4 months

Due to..... Old tuberculosis

Several years

Due to..... An acute attack

.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... Wm. H. Bier

M. D. or other

Address..... Millington Date signed..... Aug 18 1945

